MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, Item #ld Film #G390 , 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00220

00200

00033	CERTIFICATE	OI DEAIII		00030
PLACE OF DEATH			e deceosed lived, if institut	ion: Residence before odmission)
o. COUNTY Talbot	MARYLAND	o. STATE Marylo	end.	Talbot
b. CITY OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside		RAL and give nearest tawn)
St. Michaels (nural)	52 years	St. Micho	iels	30.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, Rio Vista Nursing Home	give street oddress)	d. STREET ADDRESS  Rio Visto	Cove Road	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First	Middle	Д	DATE Mont	
DECEASED (Type or print) Agnes Geneva Ben		4.	OF DEATH	June 21, 1967
SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years lost birthdoy)	Months Doys Hours Min.
Female white WIDOWED	DIVORCED	1/13/1886	87 yrs.	Months Doys Hours Min.
	IND OF BUSINESS OR NDUSTRY	11. BIRTHPLACE (County & Sto		12. CITIZEN OF WHAT COUNTRY?
3. FATHER'S NAME		Baltimore  14. MOTHER'S MAIDEN NAME		US/I
August Peterson			Anna Wisni	ewski
61		NFORMANT	Add	to Michaels, Md
(Yes, no or unknown) (If yes give wor or dotes of service)	218-09-0741 M	rs. C. B. Gre	ene. Rio Vi	sta.
18. CAUSE OF DEATH (Enter only one cause per line for		1		INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	schen	a - se	ver	ONSET AND DEATH
4200 DUE TO	4 60	4	1	Constitution of the second
Conditions, if ony, which gave	herefeli	well c	ardia	ex
rise to immediate couse (a), stating the underlying couse	0		20	PK TO K TO BE
last. (c)	leng	co val	a	
PART II. OTHER SIGNAFICANT CONDITIONS CONTRIBUTING	TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITI	ON GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED?
oderance	el senn	Recha	riefe	YES NO
200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port	l or Port II of Item IB.)	
	INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, form,	20f. (City or town)	(County) (Stote)
Hour o.m. While of wor		ory, street, office bldg., etc.)		
21. I certify that (I) (this haspital) atten		960 19	106-21	1962, that (I) (we) la
saw the deceased alive an 2 -2 0		death accurred at 2	7	and an the date stated above
220-SIGNATURE	0 1	ATTEMPTIO : NEO	CTAFF	22b. DATE SIGNED
YUM//MILES	Ser MI	D. PHYS. MED MED DIR	CTOR PHYS.	16-23-47
22c. PHYSICIAN'S NAME (Type) LUYM (14	reset h	22d. ADDRESS	i Race	md
30. BURIAL, CREMATION, 23b DATE THEREOF	23c. NAME OF CEMETERY/OR	CREMATORY	23d. LOCATION (City or To	wn) (County) (Stote)
REMBULLEU 6/23/ 1967	Woodlawn Man		Easton, M	
24. FUNERAL DIRECTOR	ADDRECC		REGISTRAR 25b. RE	GISTRAR'S SIGNATURE
"MALIRICE" E. NEWNAM & SON	, caston, Md.	DATE JUP	27 1967	garles Judge

within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cample by filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove action papers. Pages, I and should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 haurs affer deets **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed Page 4 may be retained by the haspital or attending physician.

VR A15 (4) 25M 1/67

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Talb	Providend			2003	
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that His	ris., mean production?			No. A. S. S.	20/32
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CERTIFICATE OF DEATH 08700 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside proporote limits, write RURAL and give nearest town) write RURAL and give nearest town .⊆ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled YES NO [ event, with NAME OF carbon Middle 4. DATE DECEASED (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RAC 7. MARRIED AGE (In years NEVER MARRIED remove birthday) Hours Months any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHA OUNTRY & physician c during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME MOTHER'S MAIDEN NAME or removol, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse has been last OS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? certificote 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Poor I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bidg. etc.) Hour o.m. Not While After ot work 21. I certify that (1) (this haspital) attended the deceased fram be retained TO FUNERAL DIRECTOR: saw the deceased alive an 6 - 10 1967, and that death accurred at 5 34M, fram causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR filed v M.D 22Easton, Maryland Stephen P. director, po should be f NAME (Type) 23d. JLOCATION (City or Town) Page / VR A15 (4) 25M 1/67

24 hours

within

executed

requires that the death certificate

ATTENDING PHYSICIAN:

O HOSPITAL

### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 167 kk

08701

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			and the same of
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceosed lived, if institution	
O. COUNTY TALAST	MARYLAND	o. STATE b. COUNTY  Maryland	
b. CITY OR TOWN (If outside corporate limits		c. CITY OR TOWN (If autside corporate limits, write RURA)	Caroline
write RURAL and give nearest tawn)	45 Fire.	Federalsburg	1.5. 2
d. NAME OF HOSPITAL OR INSTITUTION (If no		d. STREET ADDRESS	e IS RESIDENCE
Memorins	HOSPITAL	R.F.D. # 1- Box 277	ON A FARM? YES NO 🔀
B. NAME OF Curtis ( )	James Middle	Last 4. DATE Month OF DEATH	Doy Year
(Type or print) ) A 5	7. MARRIED NEVER MARRIED X		IF UNDER 1 YEAR   IF UNDER 24 HRS.
0. 202011 011 11112		lost hirthdoy)	Months Poys Hours Min.
	WIDOWED DIVORCED	June 6, 1967 yrs.	2
Oa. USUAL OCCUPATION (Give kind of work done	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
luring most of working life even if retired)	INDUSTRI	Easton, Maryland	U.S.A.
3. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jerome Samp	le	Dianne Cannon	
S. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17. 1	NFORMANT Address	
(Yes, no, or unknown) (If yes give wor or dotes o	Learnical	rome Sample, Federalsburg,	MA
No		Tome Sample, Pederalsburg,	Transcription of the contract
1B. CAUSE OF DEATH (Enter only one cour PART I. DEATH WAS CAUSED BY:	se per line for (a) (b), ond (c).)	1 1 1 1 1	ONSET AND DEATH
IMMEDIATE CAUSE	o Justarac	unord steeding sus	CONSET AND DEATH
160,5 DUE	TO A	\\	
Conditions, if ony, which gave	(b) STNOXIC		
rise to immediate couse (o),		7 - 4	
storing the underlying couse	10 Yrena		
		THE TERMINAL DISEASE COMPLYION OF THE PLANT IV	19. WAS AUTOPSY
PAKT II. OTHER SIGNIFICANT CONDITIONS CO	INTERBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEAS® CONDITION GIVEN IN PART 1(a)	PERFORMED?
5			YES NO Z
20o. ACCIDENT WAS UNDERLYING	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.		CE OF INJURY (Home, farm, 20f. (City or town)	(County) (Stote)
Hour o.m.		ory, street, affice bldg., etc.)	
pant.	ot work U ot work U	1067 :-	10 45-4 (1) () 1
	pital) attended the deceased fram 19 and that	death accurred at 31 M, from causes on	, 19, that (I) (we) las ad an the date stated abave
saw the deceased alive an		dealli accorred at 5 m, fram causes at	
220. SUSNATURE	All A V	ALIENVING MED. STAFF	22b. DATE SIGNED
Mulic fr	· Hugereld M.		6/12/6:/
22c. PHYSICIAN'S NAME (Type) William	A. Hatfield M.	22d. ADDRESS	6 15 - 15 -
HAMIC (Type) WIIII	A. Hatfield M.	D. Easton, Maryland	6/12/67
30. BURIAL, CREMATION, 23b. DATE THE	REOF 23c. NAME OF CEMETERY OR	CREMATORY 23d. LOCATION (City or Town	) (County) (Stote)
REMOVAL (Specify) July 1	3,1967 Rhodesdale Co	emetery Rhodesdale,	Md. RED
24. SUNERAL DIRECTOR	ADDRESS.	2So. REC'D BY REGISIRAR -2Sb. REGI	
Frant F	of la lakere ?	JUL 17 1967 X	marces judges
sucomprom dunical Hor	u dellasting 1	10 DATE	0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion ond completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon pageers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after repth. Page 4 moy be retained by the hospital or attending physicion.

VR A15 (4) 25M 1/67

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the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

Health prior to buriol, cremotion, or removal, and in any event within 72 hours ofter death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death. If

#### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS. W. PRESTON STREET, BALTIMORE, MARYLAND 21201 301

RTIFICATE OF DEATH	08700
USUAL RESIDENCE (Where deceosed lived,	
STATE /	b. COUNTY -

	08702	MEDICAL EXAM	INER'S C	ERTIFICATE O	OF DEATH	Û	8700
	PLACE OF DEATH O. COUNTY  1 A Chat	M	ARYLAND	2. USUAL RESIDENCE ( o. STATE	Where deceosed lived, if inst	titution: Residence	before odmission)  LBaT
	b. CITY OR TOWN (If outside corporate limit write RURAL and give nearest town)	7/		c. CITY OR TOWN (If a	utside carparate limits, write	RURAL and give n	eorest tawn)
	d. NAME OF HOSPITAL OR INSTITUTION (If no	ot in haspital give street address	•	d. STREET ADDRESS	TON		T e. IS RESIDENCE
	Metrovial	y w dayna, gwa shaa asqua,		a. a			ON A FARM? YES NO
	NAME OF PECEASED	irst A Middle	C	Last	4. DATE N	Month	Doy Year
_	(Type or print)	all IT.	Co	DATE OF BIRTH	9. AGE (In years	6 - /	PAR IF UNDER 24 HRS.
j.	FEMILE NEGRA	7. MARRIED NEVER MARR WIDOWED DIVOR		7 - 12-1	919 lost birthdoy	) Months D	loys Hours Min.
	. USUAL OCCUPATION (Give kind of work done			11. BIRTHPLACE (Stote		12. CITIZE	EN OF WHAT
aur	ing most of working life, even if retired)	LAUND 13	4	MD.		COUN	5A
13.	FATHER'S NAME	11 kg		14. MOTHER'S MAIDEN	NAME - 1 /		- 1 - 1
15	WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO	17 IN	17051	EFLU	9 WA	199105
(Ye	es, no, or unknown) (If yes give wor or dotes of	of service) 9 18 9 4-3	14.21	WiLLia	NI Conni	= EA	stone Mrs
	1B. CAUSE OF DEATH (Enter only one cau		14!	187	The		INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: fmmediate cause	(o) SHOCK-					ONSET AND DEATH
	Conditions, if ony, which gove )	(b) ACUTE GENER	A 1 1 7 F	D PERITO	NITIS POS	T .	
	rise to immediate couse (a)	10-	175126		on the Thirty		100
i	last.	(c)		HYSTEREC	TOMY		
N	PART II. OTHER SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT NOT R	ELATED TO TH	E TERMINAL DISEASE CO	NDITION GIVEN IN PART 1(o)		19. WAS AUTOPSY PERFORMED?
CATI	OOD OLD HEALI					4.7.2	YES NO X
L CERTIFICATION	200. EXTERNAL CAUSE WAS PRIMARY  Or CONTRIBUTING  CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY	OCCURRED. (Er	nter noture of injury in	Port I or Port II of item 1B.)	)	
MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19	20d. INJURY OCCURRED While Not While ot work at work		OF INJURY (Home, formally, street, office bidg., etc.		) (Count	y) (Stote)
	21. I certify that I taak charg	e of the remains described	abave, held	an Autapsy 🔲 ,	Inspection, li	nquiry 🗶 ,	and in my opinion
	death resulted fram: Nature	al causes X, Accident	, Suicid	· · · · · · · · · · · · · · · · · · ·		manner	
	ACTUAL Zours	1) Welter		M D ASSISTANT MEI	DICAL EXAMINER		22. DATE SIGNED
	EXAMINER'S			F O PEPUTY MEDIC		(	6-20-67
	NAME (Type) LOUIS				t, city, town, or county)		
230	D. BURIAL, CREMATION, 23b. DATE TH	EREOF 23c. NAME OF CE	METERY OR CR	EMATORY	23d. LOCATION (City of	Town)	ounty) (Stote)
70	FUNERAL DIRECTOR	TO / IVE/V	ion	2So REC	D BY REGISTRAR 2Sb.	REGISTRAR'S SIGN	NATURE

DAShiELL-EASTONMIZ

VR A15ME (5) 6M 1/67

THOW PHYCHOLISED DESIGNATION STUD Y7-02 - 37 0-

02701

1. PLACE OF DEATH a. COUNTY  A / bot  MARY	2. USUAL RESIDENCE (Where deceosed lived, if instit o. STATE b. CO	ution: Residence before admissional
	YLAND MILY	DUE EN HINE
b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)	IN 1b c. CITY OR TOWN (If outside corporate limits, write R	PURAL and give neorest town)  TAS VILLE  e. IS RESIDENCE
Memorial Hospid, give street oddress;  NAME OF First Middle	/	ON A FARM? YES NO Onth Doy Year
S. SEX 6. CÓLOR OR RACE 7. MARRIED NEVER MARRIED	Deaton OF DEATH  Deaton OF DEATH  Deaton OF BIRTH  Deaton OF DEATH  De	IF UNDER 1 YEAR IF UNDER 24 ARS.  Months Doys Hours Min.
100. USUAL OCCUPATION (Give kind of work done during most of working life eyen if retiged).  13. FATHER'S NAME	11.8IRTHPLACE (County & State, or fareign country)  MUEEN ANNI-  MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAT COUNTRY?
IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dotes of service)	17. INFORMANT Add	LATE dress CEINTBELL
18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  Conditions, if ony, which gove rise to immediate couse (a),  DUE TO	e of oraphagam	INTERVAL BETWEEN ONSET AND DEATH
stoting the underlying couse (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8UT NOT REL	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)	19. WAS AUTOPSY PERSORMED?
OR CONTRIBUTING COLORS OF DEATH	CCURRED. (Enter nature of injury in Port I or Port II af item 18.)	
20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED While Not While of work of work	20e. PLACE OF INJURY (Hame, farm, foctary, street, office bldg., etc.)	(Caunty) (State)
21. I certify that (I) (this hospital) attended the deceased saw the deceased alive of 220. SIGNATURE		, 19, that (I) (we) last s and an the date stated above.
1 22c. PHYSICIAN'S F.C. H. Schmidt	22d. ADDRESS Land	aglinde
230. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEME CONTROL 24-FUNERAL DIRECTOR APPRESS	ETERY OR CREMATORY  23d. LOCATION (City or BURNE)  25d. REC'D BY REGISTRAR  25b.  25d. REC'D BY REGISTRAR  25b.  25d. REC'D BY REGISTRAR  25d.  25d. REC'D BY REGISTRAR  25d.	Town (County) (Stote)  REGISTRAR'S SIGNATURE  OCHORUS (LINE)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral directar, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, crematian, ar remaval, and in any event, within 72 haurs after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician.

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> VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	00104	CLRIIIICAIL	OI DEATH		UDAUS
1.	PLACE DF DEATH	1	2. USUAL RESIDENCE (W	here deceased lived, If Institution: R	Residence before admission)
	a. COUNTY		a. STATE MAR	LA AAA D. COUNTY	-010-
	-111801	MARYLAND	I'JHK)	LAND	MADOI
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outs)	de corporate limits, write RURAL	and give nearest town)
	FASTO A	35 tres	RURAL	- EASTON	20-1
	d. NAME OF HOSPITAL OR INSTITUTION (if not in ho	spital, give street address)	d. STREET ADDRESS	0110101	e. IS RESIDENCE
	N = 1 1/	-//		7 P 000	ON A FARM?
_	Memorial Hes	actal.	nT.	2-Bx 99A	YES X NO
3.	NAME DF First	Middle	Last 4.	DATE Month	Day Year
	(Type or print)	Ralla	Dukac	OF DEATH	2 - 1967
5.	057	NEVER MARRIED 1 8	DATE OF BIRTH	9. AGE (In years   IF UNDER	
-	A. A.	NEVER MARRIED [ 8	-2 11 10 12	last birthday) Months	Days Hours   Min.
	EMALE WHITE WIDOWED	DIVORCED	PK 4, 1912	- 55 yrs.	
	a. USUAL OCCUPATION (Give kind of work done   10b. Kl	ND OF BUSINESS OR DUSTRY	11. BIRT HPLACE (County	& State, or foreign country)   12. C	ITIZEN OF WHAT
Uul	712	DUSTRY	CAPALINE COM	MADELLAND	CA
13	HOUSEWIFE .		14. MOTHER'S MAIDEN N	AME THE STATE OF THE P	0311
1	C /		11 -		
	GEORGE LANE		HATTIG J	AFFIN	
15	i. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. Ses, no, or unknown) (If yes give war or dates of service)	SOCIAL SECURITY NO.   17.	INFORMANT	Address	
1,.		5-16-8543 1/1	WIRM H DIW	ES. EASTON, MA	ARVI AND
=	18. CAUSE DF DEATH [Enter only one cause per lin	1777	A PINITE	, Ensity	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	(e 101 (a), (b), all (c).1	1 du Tira	May & L	ONSET AND DEATH
	IMMEDIATE CAUSE (a)	yoursul y	morning	, years	
	4201 DUE 10	1 1			
	Conditions If any which \	MIC	A.		
	gave rise to Immediate	A)	1		
	cause (a), stating the DUE TO	ma un	dealist lon	1	
-	underlying cause last. ) (c)	1000	ouco gara		
0	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU	TING TO DEATH BUT NOT RELAT	TED TO THE TERMINAL DISEA	SECONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
S		0			YES NO
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING   20b. D	ESCRIBE HOW INJURY OCCUR	RRED. (Enter nature of Inlu	ry In Part I or Part II of Item 18.	
ERI	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		titles (Ento) notello or ma	, , , , , , , , , , , , , , , , , , , ,	
CAI			E OF INJURY (Home, farm, y, street, office bldg., etc.)	20f. (City or town) (Cou	inty) (State)
MEDICAL	Hour a.m. While p.m. 19 at work	Mot while	y, succe, omegoidg., etc./		
Σ					11 1 11 1 1 1 1 1 1
	21. I certify that (I) (this hospital) attende		, 19	, to, 19	, that (I) (we) last
	saw the deceased alive on	19 and that	death occurred at 3	M, from the causes and on t	
	22a. SIGNATURE ANDIN	X			ATE SIGNED
	1 XVAON	M.D.	ATTENDING MED.	TOR PHYS.	-3-60
	22c. PHYSICIAN'S	1 7	22d. ADDRESS	- m	1
	NAME (Type) E- (-H SI	ומודות	Caple	an -Illumb	hul
-	DUDIAL ODEMATION LOSS DATE THEOREM	OD HAME OF DEMETERY	00 00544370096 1.0	24 LOCATION (CIAN FOUR OF CO.	(Ctata)
23	BURIAL, CREMATION, 23b. DATE THEREOF	11/	OR CREMATORY 2	3d. LOCATION (City, town or col	unty) (State)
	DURIAL JUNES, 1961	NOODLAWN/18	MCRIALTI+KK	EASTON, /1/AA	1 LAND
24	. FUNERAL DIRECTOR	ADDRESS	25a. REC'D B	Y REGISTRAR   25b. REGISTRAR	'S SIGNATURE
1	Henrick Por 1	1+m2	l ofe	4-7	
1	Junioun L Georgia	- Marinepas	OM THE	C 1967 OTL	of andal

	0730-
TABART CHILAVARIA	
AND SERVICE STATES	
X E HARLING STOLEN	
	THE PARTY BARRY
- CARLING COURT PLANS AND CONTROL	CONTRACTOR OF THE PARTY OF THE
HARTIN PAREIN	Sure Land
9543 Lemmit Dones Instee Mary 1917	
Entered Management Lever Mayrence	Brain Burn 1911 We

4+			DIVISION OF V		LAND STATE DEP. RDS, 301 W. PRESTO			YLAND 21201		
M)	087				CERTIFICATE				(	08703
	a. COUNTY		1bo+		MARYLAND	2. USUAL RESIDE o. STATE	,	ed lived, if institutio b. COUNT	٧	fore odmission) Anne's
	b. CITY OR write RU	OWN (If outside co	st town)	с. І	ENGTH OF STAY IN 16	c. CITY OR TOWN		te limits, write RURA	L ond give nec	rest town)
78	d. NAME OF	HOSPITAL OR INSTI	TUTION (If not in h	ospitol, give s	treet address)	d. STREET ADDRES	SS	,		e. IS RESIDENCE ON A FARM? YES NO
).	S. NAME OF DECEASED (Type or pri	6. COLOS	1	IARRIED X	Middle  Hen Ry  NEVER MARRIED   DIVORCED	Earle 8. DATE OF BIRTH 3-29-		AGE (lay reors lost by hdoy)		
			of work done etired)	10b. KIND O	BUSINESS OR CYUCTION	11. BIRTHPLACE (C	ounty & Stote, or for	reign country)	12 CITIZEN COUNTE U.S.	OF WHAT
	Jacob	H. Earle				Carrie :	L. Srode			4
	Yes, no, ar unk	SED EVER IN U.S. ARI nawn) (If yes give	MED FOR CES? war ar dotes of servi	16. SOCIA 706-		INFORMANT Lydia A	Earle,	Addres Barcl	ay, Md.	21607
	Canditions	I. DEATH WAS CAU	DUE TO  (b)  DUE TO	line for (o), (	b), ond (c).)	diseo	ىقق		V	INTERVAL BETWEEN ONSET AND DEATH
3	PART II. O	THER SIGNIFICANT (	CONDITIONS CONTRI	BUTING TO DE	ATH BUT NOT RELATED TO	THE TERMINAL DISEA	SE CONDITION GIVE	N IN PART 1(o)		19. WAS AUTOPSY PERFORMED?  YES NO
	∴ OR CONTRI	ENT WAS UNDERLYIN BUTING [] CAUSE OI NOTIFY MEDICAL EX	DEATH	20b. DESCRIB	E HOW INJURY OCCURRED.	(Enter noture of inju	ıry in Port I ar Par	t II of item 18.)		
		Of INJURY Month, our o.m. p.m.	19	2Dd. INJURY While at work	Not While of work	CE OF INJURY (Home tary, street, office bld	g., etc.)	(City or town)	(County)	
1	saw	the deceased o	) (this haspital) ilive an	) attended	the deceased fram_ 19, and tha	t death accurre	d at 7061	a 1, fram causes a	nd an the o	
	00 01114	Rober	t W.T		M.	v. [1113.	MED. DIRECTOR on, Mary	STAFF PHYS.   rland	2260115	1787
1	230. BURIAL, C	REMATION, 2	3b. DATE THEREOF une, 22, 1	23	c. NAME OF CEMETERY OR	CREMATORY etery.	23d. LO Hawt	CATION (City or Tow		N.
	24 FIINEPAL	DIRECTOR			ADDRESS	250	REC'D BY REGISTE	RAR 2Sh REG	ISTRAR'S SIGNA	TURF

ADDRESS

2So. REC'D BY REGISTRAR

(State) N.J.

2Sb. REGISTRAR'S SIGNATURE

VR A15 (4) 25M 1/67

24 FUNERAL DIRECTOR

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	conflored at a title of the		Jacob M. orle
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remave carban papers. Pages I and a trans event, within 72 haurs after death

icion and campletely filled in by the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physical director, page 3 shauld be detached far use as the burial-transit permit. Then all shauld be filed with the State Dept. of Health priar to burial, crematian, or removal,

VR A15 (4) 25M 1/67

Page 4 may be retained by the haspital ar attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08706	CERTIFICATE	OF DEATH	08704
b. CITY OR TOWN (If outside corporate limits)	MARYLAND  C. LENGTH OF STAY IN 16	2. USUAL RESIDENCE (Where deceosed lived, if ir o. STATE	Caroline
write RURAL and give nearest town)	27 days	Rural Marydel	052
d. NAME OF HOSPITAL OR INSTITUTION (If no	tin hospitol, give street oddress)  Hospital	d. STREET ADDRESS  None	e. IS RESIDÊNCE ON A FARM? YES \ NO
3. NAME OF DECEASED (Type or print) Hay d	wesley E	Lost 4. DATE OF DEATH	Month Doy Year 6 7
S. SEX Male 6. COLOR OR RACE Col.	11.	8. DATE OF BIRTH  7-10-1930  9. AGE (In year and birthdom)  36	ργ) Months Doys Hours Min.
10o. USUAL OCCUPATION (Give kind of work done during ment of working life, even if retired)	10b. KIND OF BUSINESS OR NOUSTRY	11. BIRTHPLACE (County & State, or foreign country)  Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME  John Evan		14. MOTHER'S MAIDEN NAME  Lydia Foun	tain
1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, por unknown) (If yes give wor or dotes of	service)	elen Daniels Phili	Address Pa
18. CAUSE OF DEATH (Enter only one cause PART I. DEATH WAS CAUSED BY:	1		INTERVAL BETWEEN ONSET AND DEATH
1531 IMMEDIATE CAUSE ( DUE  Conditions, if ony, which gove )		is.	5
rise to immediote couse (o), stating the underlying couse lost.	(c) Corcerionna	thousvery colo	3
PART II. OTHER SIGNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	19. WAS AUTOPSY PERFORMED? YES NO
20%. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED.	(Entermoture of injury in Port I or Port II of item 1	8.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19		CE OF INJURY (Home, form, 20f. (City or tov tory, street, affice bldg., etc.)	vn) (County) (Stote)
21. I certify that (I) (this has saw the deceased alive an_	ital) attended the deceased fram	5 / 14 , 196 2, ta 6 t death accurred at 7 A M, from col	that (I) ( law) la ses and an the date stated abov
220. SIGNATURE ST. B. C	Embler. M.	D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	22b. DATE SIGNED 6/13/67
22c. PHYSICIAN'S NAME (Type)	Ambler M.I	22d. ADDRESS  Easton, Maryland	
23o. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THE			
Burial	reof 23c. NAME OF CEMETERY OR Mt. Zion		, , ,, , ,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after.

### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08707	0	8	7	0	7
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CERTIFICATE OF DEATH

08705

				00000
		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceosed lived, if institution: Resident	
	(	a. COUNTY TAILET MARYLAND	a. STATE MARY LAND WICZM	100
		b. CITY OR TOWN (If outside corporate limits,   C. LENGTH OF STAY IN 16	c. CITY OR TOWN (If pyside corporate limits, write RURAL and give	
		write RURAL and give pearest town)	SALISTURY	100
	-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	d. STREET ADDRESS	e. IS RESIDENCE
8		Memorial -Hospital	835 E.CHURCHST	ON A FARM? YES NO D
		NAME OF DECEASED (Type or print)  First Middle  Middle  LEE	Ford. 4. DATE Month OF DEATH	18 1967
)	S. S	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED DIVORCED	8. DATE OF BIRTH 9. AGE (In years IFUNDER)  On the state of the state	YEAR IF UNDER 24 HRS. Doys Hours Min.
	100	IISTIAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR	11. BIRTHPLACE (County & State, or, foreign country) , 12. CIT	TIZEN OF WHAT
	duri	ng most of working life, even if retired) TAIL SALES, RET. GROCER		INTRY? A.
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
		Lee FORD	ESTELLE TORVER	
		WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO. 17. I  s, no, or unknown) (If yes give wor or dayes of service)	INFORMANT 306 Stdgrelvas	r St.
	(16.	MR	SELLALOLLINS EASTON, M	no.
		CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)		INTERVAL BETWEEN
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CONTROL TO	14/5	ONSET AND DEATH
		177X DUE TO	1 4 10	
		Conditions, if ony, which gove is to immediate couse (a), (b) Cast C11701773	of prostate	
		stoting the underlying couse DUE TO		
		lost. (c)		
,	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED?
	TE	20o. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port I or Port II of item 18.)	
	ER	OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
	MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLAC	CE OF INJURY (Home, form, 20f. (City or town) (Cou	inty) (Stote)
	MEC	Hour o.m. While Not While of work of work	tory, street, office bldg., etc.)	
			. 19	_, that (I) (we) last
		sow the decease dive of 109 19 , and that	t death occurred at M, fram causes and on the	
		220. SIGNATURE	ATTENDING MED STAFF 22b DA	TE SIGNED / 7
		M.E. M.E.		Vurley
		22c. PHYSICIAN'S E. C. H. SN. Homist	22d. Appress The Miles	
		P.C.11. 761111141	Copier, 1//orga	
	230.	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR 22c. NAME		(County) (Stote)
	1	SURIAL 10-0/7/8/ VVIC, MIEN,	PARK SALISOURY N	1c, MO.
	24.	FUNERAL DIRECTOR ADDRESS	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SI	
		MILL UNELAL DOME SALISOUR	14, MO DATE JUN 2 1 1967 golian	les Judge

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	08708	CERTIFICATE	OF DEATH	U	8706
	PLACE OF DEATH  1. COUNTY  1. albot	MARYLAND	2. USUAL RESIDENCE (Where deco. STATE	ceased lived, if institution: Residence b. COUNTY	before admission)
b	o. CITY OR TOWN (If outside carparate limits, write-RURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside carp	parate limits, write RURAL and give the	iearest tawn)
d	1. NAME OF HOSPITAL OR INSTITUTION (If not in h		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO
0	NAME OF First (DECEASED Vanne	Middle	last 4. DAT OF DEA		Day Year 2 196 1
F	EMALE NEARO W	ARRIED NEVER MARRIED B	3-13-1905	6 / yrs.	Days Haurs Min.
duri	USUAL OCCUPATION (Give kind of wark dane ng mast af warking life, even if retired)	10b. KIND OF BUSINESS OR , INDUSTRY	11. BIRTHPLACE (County & State, a		EN OF WHAT
13.	FATHER'S NAME US TONO US		14. MOTHER'S MAIDEN NAME  ELSI	5 HINES	٢
1S. (Yes	was Deceased ever in U.S. ARMED FORCES? s, na, ar unknawn) (If yes give war ar dates af servi		IVELLIE	= GiBSon	EASTON
	18. CAUSE OF DEATH (Enter anly ane cause per PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) DUE TO  Canditions, if any, which gave rise to immediate cause (a),  DUE TO  DUE TO	Rheumatic	heart diser	ase inaction	INTERVAL BETWEEN ONSET AND DEATH
	stating the underlying cause (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRI	BUTING TO DEATH BUT NOT RELATED TO TI	HE TERMINAL DISEASE CONDITION O	SIVEN IN PART 1(0)	19. WAS AUTOPSY
CERTIFICATION	20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (			PERFORMED?  YES NO X
MEDICAL C	(IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INURY Month, Day, Year Haur'a.m. 19		E OF INJURY (Hame, farm, ry, street, affice bldg., etc.)	f. (City ar tawn) (Caun	ty) (State)
	21. I certify that (I) (this haspital) saw the deceased alive an	attended the deceased fram	death accurred at 944	, ta, 19 M, fram causes and an the	, that (I) (we) las
	22a. SIGNATURE Robert W	. Trever MD		STAFF 22b. DATE	SIGNED
		Trever, M.D.	Easton, M	aryland	
	BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 6-6-1		on E	EASTON TALIS	aunty) (State)
24.	TUNERAL DIRECTOR	Sulso Secta La	250. REC'D BY REG	1967 JCLIANE	NATURE JULGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, without 2 hours after death

		MAKILAN	D 2	IAI	E DEPAR	IMENI	OF HEALIF	1	
DIVISION OF	VITAL	RECORDS,	301	W.	PRESTON	STREET,	BALTIMORE,	MARYLAND	21201

0870	)9	CERTIFICATE	OF DEATH		08,101
D. PLACE OF DEATH	albot	MARYLAND	2. USUAL RESIDENCE (W o. STATE	here deceased lived, if institution:  b. COUNTY	Residence before admission) TAIRAT
write RURAL on		c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If aut	side come rate limits, write RURAL	and give nearest tawn)
11-	TAL OR INSTITUTION (If not in	haspital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	Philemon	THOMAS Hom	bletm	4. DATE Month OF DEATH	Doy Year 17 19 6 7
MALE	WHITE	VIDOWED DIVORCED	90610, 191	3 53 yrs. M	UNDER 1 YEAR IF UNDER 24 HRS. onths Days Haurs Min.
during mast af warking	N (Give kind of work dane plife even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & TALBOT  14. MOTHER'S MAIDEN N.	P 4.	12. CITIZEN OF WHAT COUNTRY? US A
THOMA	S B. HAM	1BLETON 16. SOCIAL SECURITY NO. 17. 1		BURROL Address	ws.
(Yes, no, or unkrawn)	(If yes give war ar dates af ser	219-10-5610 M			N BOZMAN, MD
PART I. DEA	TH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO	Corclian for	lecre		STRET AND DEATH
Canditians, if an	y, which gave te couse (a),	theroselevoli	word	yart d	
stating the under	) (c)	RIBUTING TO DEATH BUT NOT RELATED TO 1	CHESTERMINAL DISEASE CONC	DITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
E 20g. ACCIDENTANA	Julino 10	20b, DESCRIBE HOW INJURY OCCURRED.	utes 1	11-	PERFORMED? YES NO
₹ 20c. TIME OF INJ	G CAUSE OF DEATH ' MEDICAL EXAMINER)  URY Manth, Doy, Year		CE OF INJURY (Hame, farm,	20f. (City ar tawn)	(Caunty) (State)
р.	m. 19	While at work At While at work	ary, street, affice bldg., etc.)	1 to / - / >	that (I) (we) last
	leceased alive an		death occurred at		on the date stated above.  22b. DATE SIGNED
Z2c. PHYSICIAN NAME TYPE		Books In		HRECTOR PHYS.	6-20-61
23a. BURIAL, CREMATI	ON, 23b. DATE THEREO	F 23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City ar Town)	(County) (State)
24 FUNERAL DIRECTO	YONE LO.	1967 POZMAN	h. K		RAR'S SIGNATURE
yarrist	n by flond	ed, H. / remelle	2 /KA DATELIN	2 2 1967 006	mela Judge

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, crematian, or removal, and in any event, within 72 hours after death. Poge 4 moy be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after deoth.

THERETE B. HARRESTER. Fig. 1. Sept 18 Company of the Compa CHARLES OF THE STATE OF THE STA

08710 CERTIFICATE OF DEATH within 24 hours after death. funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission a. COUNTY b. COUNTY-MARYLAND by the c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give negrest tawn) 72 hours MICHAELS campletely filled in d. NAME DF HDSPITAL OR INSTITUTION (If not in biospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS YES | NO NAME OF Middle N. First 4. DATE Month DECEASED UNICE evept, DEATH 19 car OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 6. CDLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remave last birthday) in any WIDOWFD DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) SEAFOOD physician i COUNTRY ?, 13. FATHER'S NAME removal attending presents. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give war ar dates of service) ar crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CALISE (a) DUF TO burial Conditions, if any, which gave rise ta immediate cause (a). DUF TO stoting the underlying couse peen priar ta the last. ds nds PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? alth NO certificate 20o. ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME DF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City ar tawn) (County) (State) Haur a.m. factory, street, office bldg., etc.) After 21. I certify that (I) (this hospital) attended the deceased from M, fram causes and an the date stated above. 19\_\_\_, that (I) (we) last be retained TO FUNERAL DIRECTOR: , and that death accurred at saw the deceased alive of 22a. SIGNATURE 22b. DATESIGNED M.D PHYS. DIRECTOR directar, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) 23o. BURIAL CREMATION CEMETERY OR CREMATORY 23d. LOCATION 23c. NAME OF 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67

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CERTIFICATE OF DEATH within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the funera o. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAY and give nearest tawn) c. CITY OR TOWN (If autside corporate limits. write RURAL and give neorest tawn) ve carbon papers. Paç event, within 72 haurs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) IS RESIDENCE ON A FARM? .⊑ filled MemoRIA YES NO 3. NAME OF completely fave carbon Middle 4. DATE Month DECEASED (Type or print) DEATH reavires that the death certificate be executed S. SEX 7. MARRIED IF UNDER 1 YEAR 6. COLOR OF RACE NEVER MARRIED yeors lost birthdoy) Doys eg Ro DIVORCED 10o. USUAL OCCUPATION (Give king of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI crematian, ar removal INFORMANT (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one cause per line for (o), NTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO burial, Conditions, if ony, which gave rise to immediate couse (a), DUE TO far use as the l f Health priar ta b stoting the underlying couse has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO certificate ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TO FUNERAL DIRECTOR: After this Hour o.m. foctory, street, office bldg., etc.) Not While of work at work 21. I certify that (I) (this hospital) ottended the deceased from 19\_\_\_, that (I) (we) last be retained and that death occurred at 3 32M, fram causes and an the date stated above. saw the deceased alive on.... 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. directar, page 3 shauld be filed v M.D. PHYS. DIRECTOR 22c PHYSICIAN'S 22d. ADDRESS O HOSPITAL NAME (Type) Robert W. Trever Easton, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 2Sb. VR A15 (4) 25M 1/67

### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08712

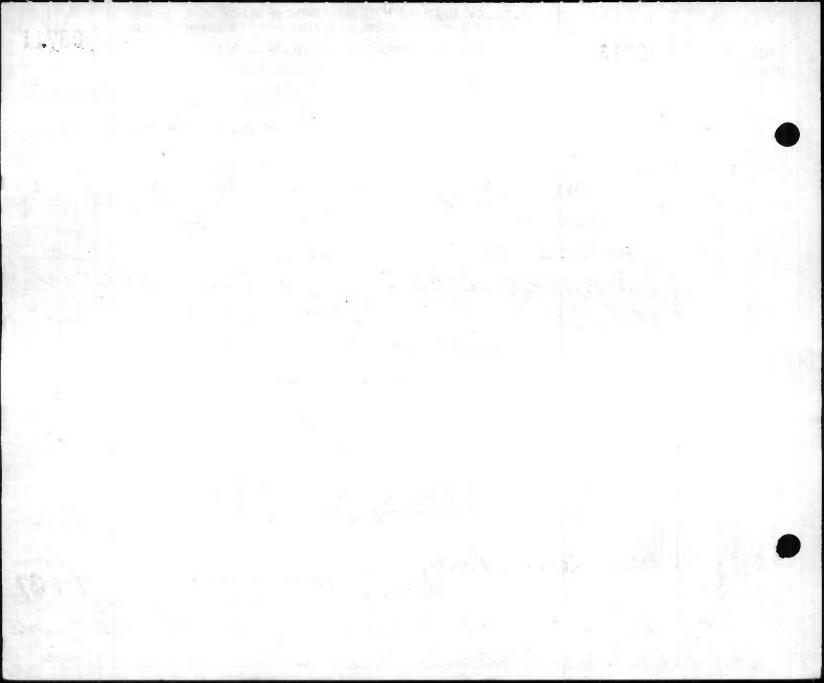
### CERTIFICATE OF DEATH

08716

UC	24 T W	CERTIFICATE	OI DEATH		00000
1. PLACE O				ere deceased lived, if institution: R	esidence before admission)
o. COUN	Mbol	MARYLAND	O. STATE AND	b. COUNTY	PALBAT
b. CITY C	OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outsice	de carparate limits, write RURAL an	nd give nearest tawn)
write	RURAL and give nearest town)	8dA.	EASTO.	N.	20.1
d. NAME	OF HOSPITAL OR INSTITUTION (If not in h	naspital, give street address)	d. STREET ADDRESS	C-1/ CT	e IS RESIDENCE ON A FARM?
	Memorial	HOSPITH1	116 HAN:	SON 31.	YES NO
3. NAME C DECEASE (Type or	ED & 1/	Middle	/ Lost 4	N. DATE Month OF DEATH	26 1967
S. SEX		MARRIED NEVER MARRIED E	B. DATE OF BIRTH	9 AGE (In years   IFU	INDER 1 YEAR   IF UNDER 24 HRS.
FEMA	HE NEGRO W	IDOWED DIVORCED	6/15/911	last birthday) Mar	nths Days Hours Min.
10a. USUAL (	OCCUPATION (Give kind of work dane of working life, even if retired),	10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County & St	tate, ar fareign country)	12. CITIZEN OF WHAT
doning most	COMES TIC	DOMESTIC	TALBOT	MO.	USA
13. FATHER	R'S NAME	7	14. MÖTHER'S MAIDEN NAM	WE C	
	JAMES 1	7 onto	na	NNOWN	
1S. WAS DI (Yes, no, or	ECEASEO EVER IN U.S. ARMED FORCES? unknown) (If yes give wor or dotes af serv	16. SOCIAL SECURITY NO. 17. II	NFORMANT I'LLI'AN	1 RELLUI	EASTOR, ME
	AUSE OF DEATH (Enter only one cause pe	Line far (a), (b), and (c).)			INTERVAL BETWEEN
P	PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)	Carerney O	celenien	a	INST AND DEATH
	4201 DUE TO				1
	ions, if any, which gave (b)	Coronary Ante	rio sclavos	99	lyr',
	the underlying cause DUE TO				
last.	) (c)				
PART I	II. OTHER SIGNIFICANT CONDITIONS CONTRI	IBUTING TO DEATH BUT NOT RELATED TO T	HE TERMINAL DISEASE CONDIT	TION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
S 200 AC	CCIDENT WAS UNDERLYING	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in Day	4 Los Dort II of Store 1D )	YES NO VI
OR COM	NTRIBUTING CAUSE OF DEATH HER, NOTIFY MEDICAL EXAMINER)	200. DESCRIBE HOW INJURY OCCURRED.	citier flatore at injusy in Par	Trairentiatientis.	
20c. T	TME OF INJURY Month, Day, Year Haur a.m.		E OF INJURY (Hame, farm, ary, street, office bldg., etc.)	20f. (City or town)	(County) (State)
WE	p.m. 19	While Nat While at work I factor	ary, street, office blug., etc.)		
21	. I certify that (I) (this hospital	) attended the deceased from	, 19		19, that (1) (we) last
so	w the deceased alive an	19, and that	death accurred ot_		on the date stoted obove.
J20	SIGNATURE & M.MST	Jane 1001 ma	ATTENDING ME	CTAFF	2b. PATE SIRNED
224.	PHYSICIAN'S		22d. ADDRESS		
	NAME (Type) Robert Mc Don	ald M.	D. Easton, Ma	aryland (	6/27/67
	AL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City or Town)	(Caunty) (State)
132	VAL (Specify) AL 6-30-	-67 11: Ch/491	2500	EASTON-TA	-LBot MIZ
24. FUNER	RAL DIRECTOR	ADDRESS	2So, REC'D B	Y REGISTRAR 2Sb. REGISTR	AR'S SIGNATURE
11/	- 11 .	B) [ [ ] [ ]	CTT 1 ALL 1	I IUUI Kooda	A TURNY WATER TO THE TOTAL PROPERTY OF THE PARTY OF THE P

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and should be filed with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours after deat Page 4 may be retained by the haspital or attending physician. VR A15 (4) 25M 1/67

118 1 146 1817 Congress O educina Comment Arterlaselaselas leaving & M.M. till & J.



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00114	CERTIFICATE	OF DEATH		CONTE	,
1. PLACE OF DEATH  o. COUNTY  A A 1 L . +	44574440	2. USUAL RESIDENCE (When a. STATE	e deceased lived, if institution:		ion)
b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside Reval	e carporote limits, write RURAL - ST. Mich		)./
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspi	ritel	d. STREET ADDRESS	.5	e. IŠ RES ON A YES	IDENCE FARM2 NO
3. NAME OF DECEASED (Type or print) Stanton	Ray L	illy	DATE Month OF DEATH  G	17 19	67
S. SEX  6. COLOR OR RACE  7. MARR  WIDOW	VED DIVORCED	8. date of birth  Det 24, 192	lost birthday) N	Nonths Doys Hours	Min.
during mast af working life, even if retired)	b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Sto	Kest Virginia	12. CITIZEN OF WHAT COUNTRY?	7
13. FATHER'S NAME Shelly Gould Lilly		14. MOTHER'S MAIDEN NAM	rimm		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknawn) (If yes give war ar dates of service)	235-26-1759 h	Mrs. Charles	Smith, Ches	peake, Visa	inio
1B. COUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	e for (a), (b), and (c).)	andi O	nfanctie	INTERVAL BE ONSET AND	TWEEN DEATH
Canditians, if any, which gave rise to immediate cause (a), stoting the underlying couse last. (c)	ypertensive	d'arterios (	Perotic Reart	disease 2/1	known
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTI	ING TO DEATH BUT NOT RELATED TO 1	THE TERMINAL DISEASE CONDIT	ION GIVEN IN PART 1(a)	19. WAS AUT PERFORM YES	TOPSY MED? NO
20c. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year Haur o.m.	b. DESCRIBE HOW INJURY OCCURRED.		I or Part II of item 18.)		19-1
20c. TIME OF INJURY Manth, Day, Year Your Day, Pear Hour o.m. 19 at	Od. INJURY OCCURRED While Nat While of work factor	CE OF INJURY (Home, farm, tary, street, affice bldg., etc.)	20f. (City or tawn)	(County)	(State)
21. I certify that (I) (this haspital) at saw the deceased alive an	tended the deceased fram 19, and that		M, fram causes and	_, 19, that (1) (d an the date state	(we) las d abave
22c. PHYSICIAN'S NAME (Type)	Trever M.C	D. ATTENDING MEDIR DIR 22d. ADDRESS  EAST ON	ECTOR LI PHYS. LI		
230. BURIAL CREMATION, REMOTE (Specify) 23b. DATE THEREOF Survey 1946	23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City or Town)		(Stote)
24. FUNERAL DIRECTOR	1 Apples	So. REC'D BY	REGISTRAR 256 REGIS	TRADY SIGNATURE	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by they directar, page 3 shauld be detached far use as the burial-transit permit. Then please remays—at bon papers. Pages shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remayal, and in the State Dept. af Health priar ta burial, crematian, ar remayal, and in the State Dept. Page 4 may be retained by the haspital or attending physician.

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	08715	CERTIFICATE	OF DEATH		08713
Ti	. PLACE OF DEATH			here deceased lived, if institution	
	a. COUNTY TAIBOT	MARYLAND	a. STATE	D. COUNTY	TALRIT
		ENGTH OF STAY IN 16	c. CITY OR TOWN (If aut	side corparate limits, write RURA	L and give nearest tawn)
	write RURAL and give neorest town)	31 days	1204	AL OF	75 20.1
1	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give st	reet oddress)	d. STREET ADDRESS	71.	e. IS RESIDENCE
	Memorial Hospita	1			ON:A FARM?
1	. NAME OF First	Middle	Lost	4. DATE Month	Doy Year
	(Type or print) CLARENCE	MA	LCKEN	OF DEATH	- 14-1967
3	. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED B.	DATE OF BIRTH		Manths Dovs Hours Min
	MALE NEARO WIDOWED	DIVORCED [	118	84 (ast birthday) yrs.	Manths Doys Hours Min.
		F BUSINESS OR	11. BIRTHPLACE (County 8	State, or foreign country)	12. CITIZEN OF WHAT
0	uring most af warking life, even if retirgd) [1]	4	TALBO	T MD.	COUNTRYS
	3. FATHER'S NAME	-	14. MOTHER'S MAIDEN N	AME	0 /
	THEOVORE MAG	NEY	MEI	BECCA -	TINNOM
			IFORMANT	Address	NEW YORK
	(Tes, no, or unknown) (If yes give wor ar dotes of service) 29 c	-32 4968 A	HARI	RIET ROM	IERO-
F	18. CAUSE OF DEATH (Enter only one couse per line for (o), (	b), ond (c).)	2.01	1 1	INTERVAL BETWEEN
	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	recrel	eaf n	marcheo.	ONSET AND DEATH
	4201 DUE TO	0.	7	V	21
	Canditians, if ony, which gove (b) (b)	refelle	otie co	convery d	yg,
	stating the underlying couse DUE TO				
	lost. (c)				
2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE	ATH BUT NOT RELATED TO TH	HE TERMINAL DISEASE CON	DITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED?
TAN	alberoselenesis ger	recarge	9 -		YES NO
CEDITICATION	206. ACCIDENT WAS UNDERLYING ☐ 206. DESCRIBE OR CONTRIBUTING ☐ CAUSE OF DEATH	E HOW INJURY OCCURRED. (F	Enfer nature of injury in P	Port I or Port II af item 18.)	C
1	(IF EITHER, NOTIFY MEDICAL EXAMINER)				
THE PARTY AND	20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY While		E OF INJURY (Home, form, ry, street, office bldg., etc.)	, 20f. (City or town)	(County) (State)
1	p.m. 17 at work	ot wark		12/11	15
	21. I certify that (I) (this haspital) attended t		+ (3,19	10 le 14	, 19(e, that (I) (we) last
	saw the deceased alive an	_19 and that	death accurred at_	4 # M, from causes ar	nd an the date stated above.
	226. SIGNATURE	1 /2		MED. STAFF	22b. DATE SIGNED
1	22c. PHYSMAN'S	M.D.	PHYS. LANDRESS	DIRECTOR L PHYS. L	4 1/14/
	NAME TYPE 1 11 200 1	est to	17111	iiMorl.	Mel
=	3a. BURIAL CREMATION, / 23b. DATE THEREOF 23	C. NAME OF TEMETERY OR C	DEMNIOOVE	23d. LOCATION (City or Town	(Caunty) (State)
1	REMOVAL (Specify) / 6-19-67	01-11	SON	EASTON	tain to fine
-	24. FUNERAL DIRECTOR	MODRESS ADDRESS	25g REC'D	BY RECISION REGI	STRARS IGNATION
	B& Dashiell		JUN I	9 1961	

death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 I Page 4 may be retained by the haspital ar attending physician. I and 2

uneral

carbon papers. Pages 1 and 2 entrough 72 haurs after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletery filled in director, page 3 shauld be detached far use as the burial-transit permit. Then please remave/carbon papers shauld be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event within 72 h VR A15 (4) 25M 1/67

The second secon

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VR A15 (4) 25M 1/67

08716 f. PLACE OF DEATH Middle 6. COLOR OR RACE 7. MARRIED

CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. Slale ryland ATCOUNTS t Easton, Maryland

o. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 days CASTON e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT# 2 Box# 232, Easton, Md Memoria NO 4. DATE Year 3. NAME OF DECEASED OF DEATH 19 67 Madison une (Type or print) UNDER 24 HRS 9. AGE (In years S. SEX 8. DATE OF BIRTH Set birthdoy) Months 9- 12-1913 Negro Male WIDOWED DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10a, USUAL OCCUPATION (Give kind af work done COUNTRY? NOTIO during mest of working life, even if retired) Connellsville. Penna. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Unknown by widow Unknown by Widow 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or unknown) (If yes give wor or dates of service Grace Madison (widow) same as above 171-16-3127 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) S DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse WAS AUTOPSY PERFORMED? THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PARTAL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CERTIFICATION NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part 11 of item 18.) 200. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e. PLACE OF INJURY (Home, farm. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED Hour o.m. factory, street, affice bldg., etc.) of work

21. I certify that (I) (this hospital) attended the deceased fram 19 47, and that death accurred at A M, fram causes and an the date stated above. saw the deceased alive and une 7 22o. SIGNATURE \

M.D.

	1	000		
2c.	PHYSICIAN'S NAME (Type)	RICHARD	TYSON	

22d. ADDRES

23c.	NAME	OF	CEM	ETERY	OR	CREMATORY
1	Ira	pr	00	Ce	ma	tery

23d. LOCATION (City or Town) Trappe. Talbot

(Stote)

(County)

BURLMOVAL (Specify) 24. FUNERAL DIRECTOR

23o. BURIAL, CREMATION,

6-10-1967

23b. DATE THEREOF

PHYS

BEAUTY OF THE PARTY OF THE PART SOVERED THE REPORT OF 13 . 7 . 7 . 3 Land I find the second Designation and the contraction of 128 S 128 S 25 S

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00715

00111	CERTIFICATE	OF DEATH		00410
1. PLACE OF DEATH a. COUNTY Talbot	MARYLAND	2. USUAL RESIDENCE (Who a. STATE Mary)	ere deceased lived, if institution b. COUNT	
b. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town)  St. Nichaels (Rusa	c. LENGTH OF STAY IN 16  3 days	c. CITY OR TOWN (If autsi	de carparate limits, write RURA	L and give nearest tawn)
d. NAME OF HOSPITAL OR INSTITUTION (If not in Rio Vista Nursing )		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO EX
3. NAME OF DECEASED (Type or print) Barbara K.	Mulder Middle	Last	4. DATE Manth OF DEATH  June	ne 16 167
S. SEX 6. COLOR OR RACE 7 Female white	. MARRIED NEVER MARRIED NOT	B. DATE OF BIRTH 1878	9. AGE (In years	Manths Days Haurs Min.
10a. USUAL OCCUPATION (Give kind af wark dane during past af warking life, even if retired) THOUSEWOAR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & STALL OF TALL	Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jacob Bryan		14. Mother's Maiden NA Elizabeth	Dolby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af so	ervice)	INFORMANT VIS. Nellie G	Address	ton. Md.
1B. CAUSE OF DEATH (Enter only one cause PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  Canditions, if ony, which gave rise to immediate cause (a), stating the underlying cause lost.  (c)	Chamic !	Gelory	Mirele	JAJERVAL BETWEEN OUSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE COND	TION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in Pa	rt 1 ar Part II af item 1B.)	
20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19		ACE OF INJURY (Hame, farm, stary, street, affice bldg., etc.)	20f. (City ar town)	(Caunty) (State)
21. Sertify that (1) (this hasping saw the deceased alive and the service of the	of) ditended the decoused from 1967, and the	at death occurred at	PET STAFF PHYS.	A, 19 A, that (I) (we) las nd an the date stated abave 22b. DATE SIGNED
23a. BURIAL, CREMATION, PRINOVAL (Specify) 6/19/10			23d. LOCATION (City or Town  Easton, Mo BY REGISTRAR 25b. REG	
24. FUNERAL DIRECTOR  MAILRICE & NEUMAM &				ISTRAR'S SIGNATURE

completely filled in by the funeral aye can an papers. Pages 1 and 2 years, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 shauld be detached far use as the burial-transit permit. Then please remashauld be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in the Page 4 may be retained by the hospital or attending physician.

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1		08718			CERTIF	ICATE	OF DEATH			US.	110	
		PLACE OF DEATH b. COUNTY	Talbot		MAR	YLAND	2. USUAL RESIDENCE (V		lived, if institution b. COUN	on: Residence be	efare admisses	sion)
	b	o. CITY OR TOWN (I write RURAL and	If autside corporate limit Laive nearest tawn)	s,	c. LENGTH OF STAY		c. CITY OR TOWN (If ou Cambric		limits, write RUR	AL and give nea	09.	2
2	C		norial	Hospital,	give street address)		d. STREET ADDRESS 31.9 Tre	enton S	treet			FARM? NO X
	[	NAME OF DECEASED (Type or print)	Lill	rst /	Middle Bell	Ni	blett	4. DATE OF DEATH	June	1		ear 67
	5. 5	Female	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIE		3 -1-189		AGE (In years Jast birthday) yrs.	Months Da		ER 24 HRS. Min.
	10a. durii	USUAL OCCUPATION ng mast af warking Housewi.	(Give kind af wark dane life, even if retired) L C		IND OF BUSINESS OR NDUSTRY OME		11. BIRTHPLACE (County Cambridge)			12. CITIZEN COUNTI		A
	13.	FATHER'S NAME	Levin	W. Be	11		14. MOTHER'S MAIDEN N		a			
			R IN U.S. ARMED FORCES? (If yes give war ar dates o		social security no.	17. ii Mrs	NFORMANT 5 Edgar Wing	ga te,	Addre Cambrid	ge, Mar	yland	
11		PART I. DEAT  Canditions, if any, rise to immediat stating the under last.	e cause (a),	TO (b)	orefia	ner	noea			2	ONSET AND	otain.
	VIION	PART II. OTHER SI					HE TERMINAL DISEASE CON				19. WAS AU PERFOR YES 🗍	
	L CERTIFICATION						Enter noture of injury in (		of item 18.)			ر الم
	MEDICAL	Haur'a.r p.r	n. 19	While at war	rk at work	facto	E OF INJURY (Home, farm ary, street, office bldg., etc.)		(City ar tawn)	(Caunty)		(State)
		21. I certification saw the de	<b>fy</b> that (I) (this has eceased alive an_	pital) atten	ded the deceased	from and that	death accurred at	9 30 M,	fram causes o	, 19, and an the c	that (I) late state	(we) last ed abave.
		Re	Bert W.		ver	M.D	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. PATES 6/5/6	OHED	
		22c. PHYSICIAN'S NAME (Type)	Robert W	PARK	W. Trever	M.	D Easton,	Maryla	end	6/5/	67	
	I	BURIAL, CREMATIC REMOVAL (Specify Burlal	June 6				emorial Par	k Cam	TION (City or Tow bridge,	Maryla	nd	(Stote)
I	24.	. FUNERAL DIRECTO	R		ADDRESS		2So. REQ	BY RESISTRAF	100 75b. RE	BISTRAR'S SIGNA	TURE	100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the event, within 72 hours after Jean

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the hospital ar attending physician.

VR A15 (4) 25M 1/67

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08719 CERTIFICATE OF DEATH

-			
1	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residen	te befare admission)
	O. COUNTY TAILOT MARYLAND	o. STATE DORUGAN A b. COUNTY	ENHNNES
H	b. CITY OR TOWN (If autside carporate limits,   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If obtside corparate limits, write RURAL and give	
1	write RURAL and give nearest town)	CENTREVILLE	17.2
1	d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE
L	Memorial HospiTAl		ON A FARM? YES NO
3	NAME OF First Middle Middle	D Last 4. DATE Manth	Day Year
L	(Type or print) JOhN IENERE!	AYNE DEATH G-	13-1967
S		B. DATE OF BIRTH  9. AGE (In years lif UNDER Months)  Months	YEAR IF UNDER 24 HRS. Days Hours Min.
1	MALE WhitE WIDOWED DIVORCED	JANUARY 25,1876 91 Yrs. Mollins	Duys Hours min.
E	Do. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR	, 11. 8IRTHPLACE (County & State, ar fareign country) 12. CIT	IZEN OF WHAT
0	uring most of working life, even if retired)  KETIRED RATE SPECIALIST COMMERCE COMMISSION	DADEVILLE, ALABAMA L	UNIRYS, A.
	3. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	William HENSLEY PAYNE	SARAH FRANCES JENNIN	395
		NFORMANT DAUGHTER Address	
1	S. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no grunknawn) (If yes give wor ar dates af service)	s. William L. FRANKLIN, CENTREVIL	6 Md
F	18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)	, volidal A IMPK (IN , Service)	INTERVAL BETWEEN
L	PART I. DEATH WAS CAUSED 8Y:	0'0:00 time	ONSET AND DEATH
ı	IMMEDIATE CAUSE (o) Verteur Cor	geo wearton	2 10 marga
	Canditions, if any, which gave ) (b) arterios les	ati antiliano	Thenous
	nse ta immediate cause (a), (	to the francisco	0014-1-0-001
Г	stating the underlying cause (c)		UNIVERSE
L	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION CIVEN IN PART 1/g)	19. WAS AUTOPSY
NO	Chronic Irain syndrome due to cerel	A silver to the state of the st	PERFORMED?
TA CAT	20g. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED.	cala Fracture left hume	AES   NO X
CEDTIELCATION	OR CONTRIBUTING TO COURSE OF DEATH	(Enter nature of injury in Part I or Part II of item 18.)	
		n tome	
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAI While Not While	CE OF INJURY (Hame, form, ory, street, affice bldg., etc.)	inty) (State)
13	p.m. 19 atwark 🗀 atwork		
	21. I certify that (1) (this haspital) attended the deceased fram_	6/16, 1967, ta 6/13, 196	7, that (I) (we) last
		death accurred at 1145,M, fram causes and an th	
	220. SIGNATURE	ATTENDING MED. STAFF 22b. DA	TE SIGNED
	Robert W. Frever M.	PHYS. DIRECTOR PHYS. 16-1	4-67
	22c. PHYSICIAN'S NAME (Type) Robert W. Trever M. D.	Easton, Maryland 6/14	167
-	inanc() [po)	0/14/	01
2	30. BURIAL, <del>(REMATION)</del> , 23b. DATE THEREOF 23c, NAME OF CEMETERY OR	A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(Caunty) (State)
1	BURIAN June 16, 1967 FORT LINCOLD	CENETERY WAShington,	D.C.
	84. FUNERAL DIRECTOR  Basto B. Basto Basto Bas Con House See M.	250. RIC'D BY REGISTRAR CEGISTRAP'S SI	MATURE
W	I TO WELL TO THE TAXABLE OF THE PROPERTY OF TH		A A

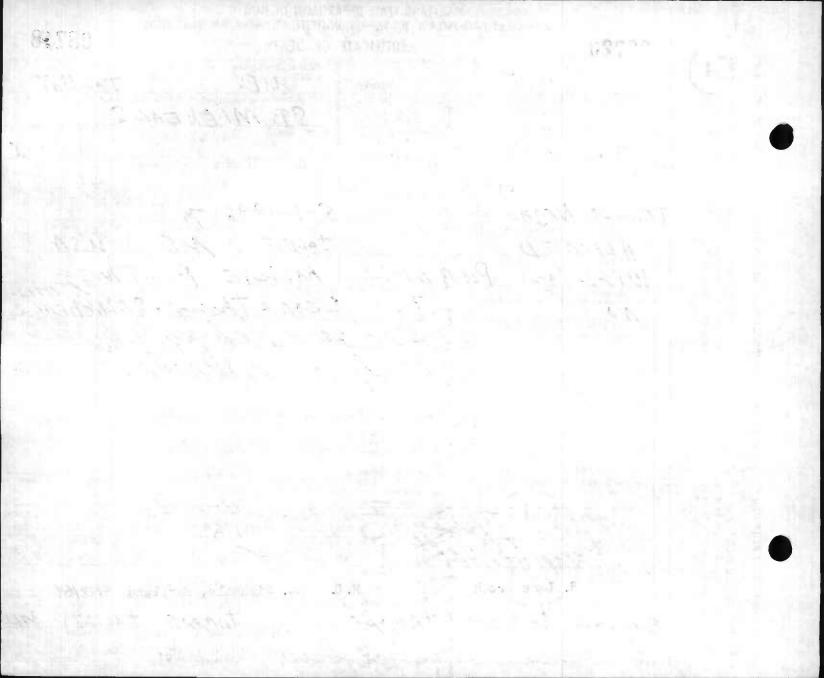
CERTIFICATE OF DEATH

08720

08718

	001130	
1.	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
	o. COUNTY ARYLAND	O. STATE ALD. b. COUNTY TALBOT
	b. CITY OR TOWN (If outside corporate limits,   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)
	write RURAL and give neorest town)	CT. MICHEALS 201
	FASION JOUR	31.11.011211-
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
	MAMORIAL POSPITAL	YES NO NO
3.	NAME OF First Middle	Lost 4. DATE Month Doy Year
	DECEASED (Type or print)	eout DEATH 6 2/ 1967
S.		B. DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.
t	EMALE NEGRO WIDOWED A DIVORCED	5-1-1896 Jost birthday) Months Doys Hours Min.
L	USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR	11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT
	ing most of working life, eyen if retired) INDUSTRY	COUNTRY?
_	METIPE D	JALDOL MU. USH
3.	FATMER'S NAME	14. MOTHER'S MAIDEN NAME
	WILLIAM PUBNELL	MOHIE PININEY
15	10t and data of conicol	NFORMANT Address /HD.
()	es, na, ar unknawn) (ir yes give wor ar dates at service)	LEONA [home, S-ST. MichEALS.
-	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	MANO BEATH ONSET AND BEATH
	1MMEDIATE CAUSE (o)	The territory of the territory of the
	DOE TO SALL INCHES	ander Vieleller Ingen
	Conditions, if any, which gave is to immediate couse (a),	Chilles Harri 1001 1 min
	stating the underlying couse DUE TO	
	lost. (c)	
7	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?
TIO		YES NO NO
FICA	2Do, ACCIDENT WAS UNDERLYING ☐ 2Db. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port I or Port II of item 1B.)
ERT	OR CONTRIBUTING CAUSE OF DEATH	y-section and the section of the sec
AL C	(IF EITHER, NOTIFY MEDICAL EXAMINER)	CE OF INJURY (Home, form, 2Df. (City ar town) (County) (State)
MEDICAL CERTIFICATION		ory, street, affice bldg., etc.)
Z	p.m. 19 of work at work	2) 15 1
	21. Legitify that (1) (this hospital) attended the deceased fram	
	saw the deteased alive an 21 Mul 1967, and that	beath accurred at 132 M, fram causes and an the date stated above.
	22a/SKGNATUPE	ATTENDING 22b. DATE SIGNED
	MICHALLI MACA MIC	D. ATTENDING DIRECTOR DIRECTOR PHYS. DIFFERENCE PHYS.
	22c. PHYSICIAN'S	22d. ADDRESS
	(NAME (Type) R. Lane Wroth M. I	St Wicharle Warrand 6/00//2
72	D. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	CREMATORY 23d. LOCATION (City or Town) (County) (State)
23	REMOVAL (Specify)	CKEMINION (COUNTY) (STORE)
1	SUA1146 10-78-61 11/4PPE	IMATER LACES MILL
2	FUNERAL DIRECTOR ADDRESS ADDRESS	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	Dashaelle Tunesal X	Lange JUN 27 1967 Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please femove carbon papers. Pages I have also be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours of the design and a should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours of the design and a should be filed with the State Dept. Poge 4 moy be retained by the hospital or ottending physician. VR A15 (4) 25M 1/67



08721

CERTIFICATE OF DEATH

08719

	CERTIFICATE OF DEATH	20.10
1. PLACE OF DEATH		osed lived, if institution: Residence before admission)
o. COUNTY.	MARYLAND O. STATE Marulan	d b. COUNTY Talbox
		prote limits, write RURAL and give nearest tawn)
write RURAL and live nearest town)	23hR. 35 M. Easton	201
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give	street address) d. STREET ADDRESS	e. IS RESIDENCE
Esstau Momerial &	ass 20 Park Str	on a Farm?
3. NAME OF First	/ Middle Last 4. DATE	
(Type or print) TAMES	HARRISON ROSS, SR. DEAT	H JIING 18 1967
S. SEX 6. COLOR OR RACE 7. MARRIED		O ACC (In IF HADED 1 VEAD IF HADED OATING
male white WIDOWED	DIVORCED   June 3. 1906	los birthday) yrs.   Months   Days   Haurs   Min.
10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND (	OF BUSINESS OR 11. BIRTHPLACE (County & State, or	fareign country) 12. CITIZEN OF WHAT
during most of working life ever fretired tenance NDM	anning Talbot Mary	land CUSA?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
J. Haddaway Ross	Emma Mullikin	
Dr. I blis to the state of the	IAL SECURITY NO. 17. INFORMANT	Address
no 217.	-14-8632 Mrs. J. Harry Ros	is, Easton, Ild.
18. CAUSE OF DEATH (Enter only one couse per line far (a),		INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ute myocardial e	Partion ONSET AND DEATH
TOO DUE TO	2 - +: 0	+
Conditions, if any, which gave (b)	herosclerotic hea	nt deserse Uncert.
stating the underlying couse DUE TO		- Can
last. (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D	DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GI	VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
Chronie obstruc	tive pulmonarys	emphysema YES   NO
2Da. ACCIDENT WAS UNDERLYING \( \text{20b. DESCRIPTION OF CONTRIBUTING } \( \text{1.20b. DESCRIPTION OF CONTRIBUTING } \)	BE HOW INJURY OCCURRED. (Enter nature of injury in Part 🗣 P	art II of item 18.)
LUI CITTER, NOTIFE MEDICAL ENAMINER)		
		(City or tawn) (Caunty) (State)
Haur'a.m. p.m. 19 While at wark	Nat While factory, street, affice bldg., etc.)	
21. I certify that (I) (this haspital) attended	the deceased fram, 19,	to, 19, that (I) (we) last
	19, ond that death occurred at 1146	
22a. SIGNATURE	ATTENDING _ MED.	STAFF 22b. DATE SIGNED
Robert W. Tru	M.D. PHYS. X DIRECTOR	□ STAFF □ 6/19/67
22c. PHYSICIAN'S Robert W. Trever	M.D. Easton, Mary	and
DCHOVAL (C:E-)		LOCATION (City ar Tawn) (County) (State)
Burial 6/22/1967  24. FUNERAL DIRECTOR	Spring Hill ADDRESS A 2Sa. REC'D BY REGIS	TRAR 256. REGISTRAR'S SIGNATURE
44. TUNLAND DIKECTUR \		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour Page 4 may be retained by the haspital or attending physician.

and completely filled in by the Toneral remove carbon papers. Pages 1 and 2 gay event, within 72 haurs after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and director, page 3 should be detached far use as the burial-transit permit. Then please remshould be filed with the State Dept. of Health prior to burial, crematian, ar remaval, and the state of the s VR A15 (4) 25M 1/67

6,30 son as issisterian U. LANGE OF CHANGE MARKET Ver one of the 9111: 9.18 adjusted thindevence family ... that the three law Sir in the second at all and a second of the second as March - And Arter Performance In the Comment of the Mobers W. Proyer Period 1/2/1967 Speling 1011 , cestave, . . ,

MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Maryland Caroline PM3. Page af MARYLAND delay Department b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) hs. Federalsburg aston d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) arm South Main Street dges YES NO [ certificate shauld be executed within 24 haurs after death. NAME OF Middle 4. DATE Lost Year DECEASED Clayton Give 05500 (Type or print) 001 DEATH 19 Examiner's Office along pages land 2 with S. SEX IF UNDER 6. COLOR OR RACE/ 8 DATE OF BIRTH 9. AGE (In years 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Item 18. Dovs Hours July 18, 1910 Male White death. WIDOWED DIVORCED 56 yrs. 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? ofter ( INDUSTRY , u Caroline County, Md. Canning House Operatorand Mgr. pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME haurs ( John Rosser Emma S. Dalious permit. File 2 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 4 should be farwarded to the Chief Medical (Yes, no, or unknown) (If yes give war or dates of service) "pending" event within J. Edwin Rosser, Federalsburg, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN burial-transit CHSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) chronic ales holisum writing the ward DUE TO any Conditions, if ony, which gove nse to immediate couse (a). = DUE TO stoting the underlying couse 0 SD be used WAS AUTOPSY removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? the certificate, YES X 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 3 shauld PRIMARY | or CONTRIBUTING | 0 EXAMINER: CAUSE OF DEATH. cremation, 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While may be retained far your FUNERAL DIRECTOR: Page Page of work of work 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection Inquiry and in my opinian Natural couses funeral director. death resulted from: Accident Suicide Undetermined monner Homicide | CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE M D DEPUTY MEDICAL EXAMINER EXAMINER'S THORSTON HARRISON Health Address (Street, city, town, or county) NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) 50 REMOVAL (Specify) Federalsburg, Caroline Md. Hill Crest Cemeterv 1967 Buria1 2Sa. REC'D BY REGISTRAR 25h. REGISTRAR'S SIGNATURE

DATELLN

VR A15ME (5)

6M 1/67

QUESTION OF THE PROPERTY OF TH 222.00 a label and the second and a second a second and a second a second and a second and a second and a second and a second and

#### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

		08723	CERTIFICATE	OF DEATH		08721
		PLACE OF DEATH D. COUNTY  TALBOT	MARYLAND	2. USUAL RESIDENCE (W o. STATE	here deceased lived, if institution b. COUNTY	
		o. CITY OR TOWN (If autside carparate limits, write PURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	EAST	side carparate limits, write RURA	20.1
0	d	1. NAME OF HOSPITAL OR INSTITUTION (IF not in 1) 203 ELWOOD AVE	nospital, give street address)	d. STREET ADDRESS 703 EL	WOOD AVE	e. IS RESIDENCE ON A FARM? YES NO
	(	NAME OF DECEASED Type or print)  ARTHA	AMELIA	Last	4. DATE Manth OF DEATH UNA	
	S. S	I W. W	IDOWED DIVORCED	DEC 27,12	879 87 yrs.	Manths Days Hours Min.
	duri	USUAL OCCUPATION (Give kind of wark dane ng.most of working life, even if retired)	106. KIND OF BUSINESS OR INDUSTRY HOUSEKEEDER	DELAN		12. CITIZEN OF WHAT COUNTRY?
		FATHER'S NAME SOLLAR. PICHAR	LCANN	14. MOTHER'S MAIDEN N.	+ CATTS	
	1S. (Yes	was deceased ever in u.s. armed Forces? s, no of unknown) (If yes give war or dotes of serv	rice	NFORMANT PE OPAN IS	P. HARRISON, 2	1//
		18. CAUSE OF DEATH (Enter only one cause pe PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	r line for (o), (b), and (c).)  erebral Vasc	ulan Occ	lusian	INTERVAL BETWEEN ONSET AND DEATH
		Conditions, if any, which gave rise to immediate cause (o),	Cerebral AT	haroscle	Evosis,	
		stating the underlying cause   DUE TO	IDUTING TO OFATH DUT NOT DELATED TO T	TENNINAL DISTACT COM	DITION CIVEN IN DART 1/->	LIO WAS AUTOPSY
3	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRI				19. WAS AUTOPSY PERFORMED? YES NO
		20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	205. DESCRIBE HOW INJURY OCCURRED. (			
	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19	While Not While of wark at work	E OF INJURY (Hame, farm, ory, street, office bldg., etc.)	My 1 2.	(County) (State)
		21. I certify that (1) (this haspital saw the deceased alive an 220. SIGNATURE		death accurred at	OP M, from causes a	that (I) (we) last and an the date stated above
		22c. PHYSICIAN'S	en 1 M.D		MED. STAFF DIRECTOR PHYS.	22b DATE SIGNED 67
1	230	NAME (Type) SKYQ  BURIAL (REMATION, 23b. DATE THEREOF	I 23c. NAME OF CEMETERY OR C	1 5	23d. LOCATION (City of Town	n) (Caunty) (State)
	-	REMOVAL (Specify)  FUNE 3 0 /		<b>-</b> S	ST. GEORGE	
		Aller Sart	Sastin V	ad DATE IL	: 30 1967 92	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remays carban papers. Pages 4 and shauld be filed with the State Dept. of Health priar ta burial, crematian, ar remayal, and in any event within 72 haurs ofter deptended. VR A15 (4) 20 M 1/66

STATE SECTION SECTION

FOR STATE	
HEALTH DEPT.	1. F

amy delay is

pending" in pencil in Item 18. Give Pages 1, 2, and

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If

necessary, please execute the certificate, writing the word

VR A15ME (5) 6M 1/67

5 may be retained far yaur files. TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages land 2 with the State Department of PMS the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm

9 Health priar to burial, crematian, ar remaval, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08723

087	24	MEDICAL EXAMINER'S	S CERTIFICATE O	F DEATH	08128
o. COUNTY		MANUALIS	o. STATE	b. COI	
	Calbot	MARYLAND	Maryl	and	Dorchester
	VN (If outside corporate limits, ond give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (II or	otside corporote limits, write RI	JRAL and give nearest town)
	aston	D.O.A.	Cambr	idge	19.2
	SPITAL OR INSTITUTION (If not in h	nospital, give street oddress)	d. STREET ADDRESS		e. IS RESIDENCE
	Memorial Hospita		723 H	ighlett/Str	eet YES NO K
3. NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE Moi	
S. SEX	6. COLOR OR RACE 7. A	MARRIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years	I IF UNDER 1 YEAR   IF UNDER 24 HRS.
				lost birthdoy)	Months Doys Hours Min.
Male	1 WELL DO		June 2,189	90 77 yrs.	
Jo. USUAL OCCUPA	TION (Give kind of work done king life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Stote	or toreign country)	12. CITIZEN OF WHAT COUNTRY?
	ndry salesma		Elliate	t Dor Count	
3. FATHER'S NAM	AE .	,	14. MOTHER'S MAIDEN	NAME	3 4 13 4
	a				
IC WAS DESCRICE	George W. To	dd	INFORMANT		ress
Yes, no or unknow	DEVER IN U.S. ARMED FORCES? wn) (If yes give wor or dotes of serv	16. SOCIAL SECURITY NO. 17	. INFURMANT	Add	ress
(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,		Mrg. H T S'	laughter, Eo	ston Md
I IR CAUSE O	F DEATH (Enter only one couse pe	r line for (a) (b) and (c))		transfer de la constitución de l	INTERVAL BETWEEN
	DEATH WAS CAUSED BY:		100		ONSET AND DEATH
	IMMEDIATE CAUSE (o)	Coronary occlus	ION		Timiled.
112					
	ony, which gove ) (b)				
	diote couse (o),				
	inderlying couse				THE RESERVE THE PARTY OF THE PA
last.	, (1) _				
PART II. OTHE	R SIGNIFICANT CONDITIONS CONTRI	BUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	NDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED?
2					YES NO NO
20o. EXTERNA	AL CALISE WAS	20b. DESCRIBE HOW INJURY OCCURRE	D (Enter nature of miner in	Port I or Port II of item ID )	1.20
PRIMARY O	or CONTRIBUTING	200. DESCRIBE HOW INJURY OCCURRE	ש. לרעופו ואינוטנה מו מולחנא וגו	ron run non nem 18.)	
CAUSE OF DEA	TH.				
200. EXTERNA PRIMARY OF CAUSE OF DEA  20c. TIME OF Hour	INJURY Month, Day, Year		LACE OF INJURY (Home, form		(County) (Stote)
Hou	r a.m.		octory, street, office bldg., etc.		
	paris	at work U of work U			. 🗖
21. I ce	rtity that I tack charge of	the remains described above,	held an Autopsy,	Inspection 🙀, Inc	quiry [_], and in my opinior
death re	esulted fram: Natural ca	uses 🔀 , Accident 🗐 , Su	uicide . Homicide	Undetermined i	monner 🗍
	0	2./	CHIEF MEDICAL		
ACTUAL	Louis	Mull	ACCICTANT NO		22. DATE SIGNED
SIGNATURE_	Jan V	way		DICAL EXAMINER L	
EXAMINER'S	1	ouis s.welty	for DEPUTY MEDIC		6-28-67
NAME (Type)	4.50	ours /s. werry	Address (Stree	t, city, town, or county)	
30. BURIAL, CREN	MATION. 236. DATE THEREOF	23c. NAME OF CEMETERY O	IR CREMATORY	23d. LOCATION (City or T	own) (County) (Stote)
REMOVAL (Sp	ecify)				
Puri	al July 1	,1967 East New	Market Cer	netery East	New Market, Md.
24. FUNERAL DIR	ECTOR	ADDRESS	NG 2So. REC	D BY REGISTRAR 25b.	REGISTRAR'S SIGNATURE
Konne	VIVE HORIO	(a) Cambridge,	Ivid .	11 9 1007	Milianelas Judges .

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## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08725	CERTIFICA	IE OF DEATH		08723
1. PLACE OF DEATH  •. COUNTY				stitution: Residence before admission)
Talbot	MARYLAND	e. STATE	Z b. COUNT	GLOUCESTER
b. CITY OR TOWN (if outside corporate limits, write RURAL and give necest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If ou	tside corporete limits, writa	RURAL end give neerest town)
Rural - St. Michael		GLASS.	BORO, N.	J. 67-3
d. NAME OF HOSPITAL OR INSTITUTION (if n	ot in hospital, give street address)	d. STREET ADDRESS		IS RESIDENCE ON A FARM?
Rio Vista Nursing H	lome			YES NO
3. NAME OF First DECEASED	Middle	Last 4.	DATE Month OF	Dey Year
(Type or print) BURRIS		IN	DEATH Jui	ne 19, 1967
S. SEX 6. COLOR OR RACE 7.	MARRIED NEVER MARRED 8	. DATE OF BIRTH	9. AGE (In years   last birthday)	
	WIDOWED DIVORCED	Dec. 5, 1881	85 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ratired)	106. KIND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (County &	State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Linotype Operator	Newspaper	Gloucester	Co., N. J.	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NA		
William Tomlin		Axey Stan	ger	
15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (Ifyes give war or datas of serv		NFORMANT	Address	
		s. Elsie Hamil	ton, Wittman.	Maryland
18. CAUSE OF DEATH [Enter only one ca		4-10	11/1/	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	14/1/1/04/1/h	Mil Creat	ral Museu	laiki Furs
1/2.2/ DUE TO	The same	160	11	1 1
Conditions, if eny, which	14/14/11/11/11	hALLE 11h	1111/11/11	WINNEY YUM.
gave rise to immediate ceuse	vousies and	in a consu	ne von	cultury 14
(a), stating the underlying DUE TO				
Z PARTH. OTHER SIGNIFICANT CONDITION	ONS CONTRIBUTING TO DEATH THE NO	T RELATED TO THE TERMINAL	DISEASE CONDITION GIVE	N IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
3 // rostalia	HUMALAK	4/1		YES NO
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	206. DESCRIBE HOW INJURY OCCURREN	D. (Enter nature of injury in Par	t I or Pert II of item 18.)	
UR CONTRIBUTING CAUSE OF DEATH				
20c. TIME OF INJURY Month, Day, Year Hour a.m.		CE OF INJURY (Home, farm, ory, street, office bfdg., etc.)	20f. (City or town)	(County) (Stete)
Hour a.m.	While Not While factor at work at work	ory, street, office brag., etc.)		
21. I costify that (I) (this hospital	Valended the deceased from	ALLS 196	Le 10.19 HLA	(C., 196.7, that (1) (we)-last
saw the deceased alive on				
222 SIGNATURE	11/	ATTENDING MED.		22b. DATE
11. 7/1/1/1/1/h	MA M	.D. PHYS. DIREC	TOR PHYS.	6-19-67
12c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
R. LANE	WROTH	St. Mich	aels, Marylan	d
23a. 8URAL, CREMATION, 23b. DATE THEREC	DF 23c. NAME OF CEMETERY	OR CREMATORY 2	3d. LOCATION (City, tow	n or county) (State)
Burial June 22,	1967 Eglington Co	emetery	Clarksboro	, New Jersey
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS -/		BY REGISTRAR 256. REG	ISTRAR'S SIGNATURE
Larison 6 deone	ed St. Mechad	p. Malostel N 2	1 1967 /	carles judge

VR A1S (4) 20M 5-63

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		940	a pair on stal	y also be
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	et. 5, 1881			- 112
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT. delay and 2, L P.M3. 4 should be forworded to the Chief Medical Examiner's Office olong with form in Item 18. Give Poges 24 hours ofter death. executed within in pencil 'pending"

permit. File pages I and 2 with the State Deportm after deoth hours within . burial-transit event Ony = Θ. ds 3 should be used removol, cremation, or moy be retoined for your FUNERAL DIRECTOR: Page buriol, be retoined Heolth prior 0

certificate should be

writing the word

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the funeral director. Poge

VR A15ME (5) 6M 1/67

CAL EXAMINER:

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b give neorest town) c. CITY OR TOWN (If write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO NAME OF First Middle 4. DATE Month Doy DECEASED (Type or print) DEATH 9. AGE (In years 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Hours WIDOWEO DIVORCED 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? MOTHER'S MAIOEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per in for (o), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURREO. (Enter noture of injury in Port I or Port II of item 18.) PRIMARY CONTRIBUTING CONTRIBUTI CAUSE OF DEATH. MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year (County) Hour o.m. foctory, street, office bldg., etc.) ot work 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection . and in my apinian Natural causes death resulted frame Suicide Undetermined manner Accident Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE BEPLITY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. 23d. LOCATION (City or Town) (Stote) (County)

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#### VARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before edmission) e. COUNTY a. STATE b. COUNTY TALBOT MARYLAND Dorchester b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) EASTON 8-1MO. CAMBRIDGE. MD. davs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? .EASTON. MD. PINES YES NO X 3. NAME OF 4. DATE Dev Year DECEASED OF (Type or print) DEATH 19 196 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. Sep 18 3 last birthday) Months Davs Hours WIDOWED IX DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Farmer, retired Dorchester, Maryland James W. Waddel Nannie C. Manning 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.1 17. INFORMANT (Yes, no. or unkown) | (If yes give we ror detes of service) B.Waddell Cambridge Md. Miss.Nannie 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 12 hr IMMEDIATE CAUSE (e) DUF TO Conditions, if any, which gave rise to immediate cause DUE TO (a), steting the underlying cause last PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO T 20e. ACCIDENT WAS UNDERLYING FT 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, ferm, ' 20f. (City or town) (County) (State) Month, Dev. Year factory, street, office bldg., etc.) Not While While Hour e.m. et work et work p.m 19, 19, 6.7 that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from ... O.c.t. saw the deceased alive on. 22b. DATE 22e. SIGNATURE ATTENDING MED STAFF SIGNED DIRECTOR PHYS. PHYS. 22c. PHYSICIAN'S 22d. ADDRESS Stephen P. Carney, NAME (Type) P.O. Box 929, Easton, Md. 21601 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF (Stete) REMOVAL (Specify) Christ Churchyard June Cambridge 24 FUNERAL DIRECTOR'S SIGNATURE

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	08728	CERTIFICATE	OF DEATH	0	8726	
	o. COUNTY + ALB ot	MARYLAND	2. USUAL RESIDENCE (When	e deceosed lived, if institution: Resi b. COUNTY	dence before odmission)  ALISOT	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	C. LENGTH OF STAY IN 16	BOVA	corporate limits, write RURAL and	20.1	
	d. NAME OF HOSPITAL OR INSTITUTION (IF not in PIBYAL OATS	-OWA HAME	d. STREET ADDRESS		e IS RESIDENCE ON A FARM? YES NO	
	3. NAME OF First DECEASED (Type or print) WALTE P  5. SEX 6. COLOR OR RACE 7.	SCOTT IN	LOST 4.	DATE Month OF DEATH JUNE  9. AGE (In years   IF UND	Doy Year 9 1967 DER 1 YEAR   IF UNDER 24 HRS.	
	11110 11	VIDOWED DIVORCED DIVORCED 10b. KIND OF BUSINESS OR	3-21-189	Iast birthdoy) Month		
	during most of working life, even if retired)  13. FATHER'S NAME	Buil Ding	TAURAT	MD-	COUNTRYSA	
	WALTE SOTT US. S. WAS DECEASED EVER IN U.S. ARMED FORCES?	ALLACE SA.	CAAA	i'E GiB.	SON	
	(Yes, no, or unknown) (If yes give wor or dotes of ser	918-14-2437	MAGGE	E HOWELL	LIMITERVAL BETWEEN	
	PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o) C  DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse last.  (c)	Mrs. Marine 15, (6), (10), (10)	sign,	Luft Lung	INSET AND DEATH	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTR	RIBUTING TO DEATH BUT NOT RELATED TO T	HE TERMINAL DISEASE CONDITI	ON GIVEN IN PART 1(o)	19. WAS AUTOPSY PERFORMED? YES NO	
	200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (	Enter noture of injury in Port	I or Port II of item 1B.)		
	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19		E OF INJURY (Home, form, ary, street, affice bldg., etc.)	20f. (City or town)	(County) (Stote)	
	21. I certify that (I) (this hespital) attended the deceased fram (5) Affal, 1962, ta (5-2), 1962, that (I) (we) last saw the deceased alive an (6-2), and that death accurred at 2 (6-2), fram causes and an the date stated above.					
	22c. PHYTICIAN'S NAME (Type)	1/rates M.D	ATTENDING DIRECTOR OF THE PROPERTY OF THE PROP	STAFF 22b.	DATE SIGNED	
	230. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREO	57 Moyal	DAT	23d. LOCATION (City or Town)  ROYAL-OKT	(County) (Stote)	
1	24. FUNERAL DIRECTOR	ADDRESS ADDRESS	250. REC'D BY	REGISTRAR 25b. REGISTRAR	SSIGNATURE	

**IO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours ofter death. Page 4 may be retained by the hospital or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician ond completely filled in by the funeyal director, page 3 should be detoched for use os the buriol-tronsit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after leaf

VR A15 (4) 25M 1/67

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# FOR STATE HEA

### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08727

HEALTH DEPT.		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
200		o. COUNTY T	CTATE COUNTY			
and 3 to M3. Page rtment of		1A/D8/ MARYLAND				
ela 3. P 3. P		b. CITY OR TOWN (If autside carparate limits, write PURAL and give-nearest town)  C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)			
2, and PM3. P		EASTON, MU	Washington, D.C. 47.3			
n 2	11	d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address)	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?			
haurs after death. If any delay tem 18. Give Pages 1, 2, and 3 Office alang with farm PM3. Pa and 2 with the State Department r death.		Memorial	5701 SHERRIFF ROAD, N. E. YES NO			
Give Pages and with far the State		NAME OF DECEASED Middle	Last 4. DATE Manth Day Year			
we we the		(Type or print) FORRES / B	WATTS OF DEATH 6 10 1967			
Ign Gi	S.		3. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Manths Days Haurs Min.			
haurs after de frem 18. Give F Office alang wi 1and 2 with the sr death.	1		7-11-46 Jast birthday) Manths Days Haurs Min.			
tem 18 are Office of set 1 and 2 v after death	10a	. USUAL OCCUPATION (Give kind of wark dane ing mast of warking life, even if retired)  10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State ar fareign country)  12. CITIZEN OF WHAT			
	Guil	STUDENT SCHOOL	WEST VIRGINIA COUNTRY?			
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME GALE PEAKS			
withm pende xanna xanna ile pag haurs		JAMES P. WATTS	GALE PEAKS			
in print Fill Fx	15.		NFORMANT Address			
executed within nating" in period Medical Examina permit. File pagaithin 72 haurs	(Ye	rs, na, ar unknawn) (If yes give war ar dates of service)	. JOSEPH BARR 5701 SHERRIFF ROAD, N. E.			
e execution pending" st Medica sit permi		18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)	INTERVAL BETWEEN			
Is. WAS DECEASED EVER IN U.S. ARMED FORCES?  Is. WAS DECEASED EVER IN U.S. ARMED FORCES?  (Yes, na, or unknown) (If yes give war ar dates of service)  Is. CAUSE OF DEATH (Enter only one couse per line for (a), b), and (c).)  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  ONSE						
ld be rd "pe Chief transit event		Y (1.7) 1) non-				
shauld a the Ch burial-tra		Canditions, if any, which gave) (b) Autoaccident				
the ta ta pun a pu		nse ta immediate cause (a), Due to				
ficate ing trded as a and i		stating the underlying cause (c)				
vertificate writing th rwarded t ised as a l val, and in		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED?			
	CERTIFICATION		PERFORMED?			
Thi at	IFICA	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (I	Enter nature of injury in Part I or Part II of item IB.)			
# P 5 b		PRIMARY □ or CONTRIBUTING □  CAUSE OF DEATH.				
INE sha sha file file iian	MEDICAL	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 2 20e. PLACE	E OF INJURY (Hame, farm, 20f. (City ar tawn) (Caunty) (State)			
EXAMINER cute the cer age 4 shau r yaur files. Page 3 sho crematian,	MED		bruka, Itreet, affice bldg., etc.) NV. Easton Talbot and			
MEDICAL EXAM lease execute the director. Page 4 etained far your DIRECTOR: Page to burial, crema		21. I certify that I took charge of the remoins described above, held				
se exector. Pour far far ECTOR: burial,		deoth resulted fram: Natural causes, 🔲, Accident 🗶 Suicid				
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Mkor please direct direct retaine DIREC		SIGNATURE A MISS /// Utte	M.D. ASSISTANT MEDICAL EXAMINER			
JTY ry, ry, leral be r RAL pria		EXAMINER'S				
DEPUTY seessary, e funeral may be may be l FUNERAL		NAME (Type)	Address (Street, city, town, or county)  6-10-67			
ro DEPUTY ME, necessary, plea the funeral dire. 5 may be retail to FUNERAL DIR Health priar to	230	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR C	( ) ( ) ( ) ( ) ( )			
7 - 1,01		REMOVAL (Specify) 6-14-67 HARMONY MEMORI	AL CEMETERY PRINCE GEORGE CO., MARYLAND			
VR A 15ME (5)	24	FUNERAL DIRECTOR ABORES 12TH	STREE 250. JECONY 1EGETRA 967 250. REGISTRAR'S SIGNATURE			
6M 1/67	Jo	HN T. RHINES FUNERAL HOME WASHINGTON	D.C. DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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death neral and death	1.	PLACE OF DEATH
Page 4 may be retained by the haspital or attending physician.  O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please pemove corban papers. Pages 1 and 2—shauld be filed with the State Dept. at Health prior to burial, cremation, ar remayal, and in any within 72 hours after death.		b. CITY OR TOWN write RURAL o
lled in boapers.		d. NAME OF HOSE
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The after has use a lith pr	TION	PART II. OTHER
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	PLACE OF DEATH			2. USUAL RESIDENCE (Whe			before admission	1)
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	b. CITY OR TOWN (If autside carparate limits,	c. LENGTH OF STAY IN	1b	c. CITY OR TOWN (If Sutsid	e carparate limits, write RU	RAL and give r	learest town)	
13	write RURAL and give nearest town)	17das	C 25 .	Trappe 1	Rural)	6.0	20.1	
	d. NAME OF HOSPITAL OR INSTITUTION (If not in he	aspital, give street address)		d. STREET ADDRESS			e IS RESIDE ON A FAR	
	Memorial H	ospital "			•			NO K
	NAME OF First DECEASED (Type or print)  The print of the	Middle (	wh	telen 4.	DATE Mon OF DEATH	th /	Doy Yest	7
S.	SEX 6. COLOR OR RACE 7. M	ARRIED NEVER MARRIED	$\Box$ $B$	. DATE OF BIRTH	9. AGE (In years birthday)	IF UNDER 1 Y	YEAR IF UNDER 2	24 HRS. Min.
	mance with	DOWED DIVORCED		pril 19, 188	Yrs.			min.
	. USUAL OCCUPATION (Give kind of work done ingmost of working life, even if retired)	10b. KIND OF BUSINESS OR HOUSTRY		11. BIRTHPLACE (County & St.	ote, or foreign country)  Manuland	12. CITIZ COU	EN OF WHAT	
13.	FATHER'S NAME	o admisocc		14. MOTHER'S MAIDEN NAM		_ u	3/1	
	William Whitley			Fannie Towe	era .	4.00		
15.	WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. IN		1.1	1612 Wa	odlea A	ve
(16	(If yes give wor or dates of servi	unkn.	Mr	s. Margaret,	Affayroux,	Baltin	none. Mr	100
	18. CAUSE OF DEATH (Enter only one couse per	line for (o), (b), and (c).)					INTERVAL BETW	VEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Uremia					ONSET AND DE	ER
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	Conditions, if any, which gave (b)	arterion	ep	Moscle	wosik	7	Uncert	un
	stating the underlying couse DUE TO					1		
	lost. (c)							
ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	SUTING TO DEATH BUT NOT RELATE	ED TO T	HE TERMINAL DISEASE CONDIT	ION GIVEN IN PART 1(0)		19. WAS AUTOP PERFORMED YES N	
MEDICAL CERTIFICATION	200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCU	URRED. (	Enter nature of injury in Part	I or Port II of item 1B.)	- 1		
ICAL	20c. TIME OF INJURY Month, Day, Year	20d. INJURY OCCURRED 2	Oe. PLAC	E OF INJURY (Hame, farm,	20f. (City or town)	(Count	(S1	tote)
MED	Hour o.m. p.m. 19	While Not While at work	facta	ry, street, affice bldg., etc.)				
	21. I certify that (I) (this haspital)	attended the deceased from	am	, 19_	, ta	, 19	, that (I) (w	e) last
	saw the deceased alive an	19, an	d that	death accurred at	M, fram causes		1 1 1	
	22a. SIGNATURE			ATTENDING 30 MED	/	22b. DATE		
	Robert W.	Trever	M.D.	PHYS. L_J DIK	ECTOR PHYS. L	6/19	1/67	
	22c. PHYSICIAN'S NAME(Type)Robert W. Tr	e <b>ve</b> r	М.	D. aston.	Maryland			
230	BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETE			23d. LOCATION (City or To	iwn) (c	ounty) (Sta	nte)
200	REMBAUTUAL 6/21/196				Trappe, 1		(510	
24	FUNERAL DIRECTOR	ADDRESS	7-4	250. REC'D BY	REGISTRAR 2Sb. R	EGISTRAR'S SIGI		

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